BCCA Employee Benefit Trust Group Enrolment Form

☐ **New Employee**
☐ **Rehired Employee**

Please send completed original to:
BCCA Employee Benefit Trust
120-4401 Still Creek Drive Burnaby BC V5C 6G9
604-683-7353 1-800-665-1077
hr@bccabenefits.ca fax: 1-604-299-2982

Name of Employer_____

Policy No._____ **Group Code** (Internal use) _____

Please Print Clearly

Employee Information

Last Name	First Name	Middle	SIN (Optional):	
Street Address	City		Prov.	Postal Code

Sex	Birth Date			Are you in Canada on a Work Visa/Permit? A copy is required for enrolment. ☐ Yes ☐ No	Are you covered under a Provincial Health Plan? (MSP in B.C.) ☐ Yes Prov.:_____ ☐ No
	Month	Day	Year		
☐ Male ☐ Female				Marital Status: ☐ Single ☐ Common Law* ☐ Married ☐ Divorced/Separated ☐ Widowed *Date of Cohabitation_____ (*Date of Cohabitation is mandatory for Common Law status).	

List Dependent(s) (if you require more room please attach another enrolment form)		Sex	Birth Date			Relationship to You	If a child is over 19, please provide the name of the full time school OR attach a copy of the notice of Approval decision from CRA if child has a disability.
Last Name (if different from your own)	First Name	M/F	Month	Day	Year		

Coordination of Extended Health and Dental or Waiver

Do you and/or your dependents have extended health or dental coverage provided under another plan? If yes you MUST complete this section.

Name of Insurance Company	Group No.	ID. No.

By checking the boxes below, I am choosing to decline the benefit for myself and my dependents
☐ Extended Health Care ☐ Dental Care

OR

By checking the boxes below, I am choosing to decline the benefit for my dependents only
☐ Extended Health Care ☐ Dental Care

Life Beneficiary Designation

_____ _____ _____%
Full Legal Name Relationship to you Share of Proceed

_____ _____ _____%
Full Legal Name Relationship to you Share of Proceed

*If you would like to add more beneficiaries than the space above allows, please add another enrolment form

Where Quebec laws apply, a spouse beneficiary is irrevocable unless you check this box designating it revocable.

☐ Revocable

An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary.

_____
Full Legal Name of Trustee (required for beneficiaries under the age of majority, 19 in B.C.)

OR, by checking this box ☐ I am assigning my estate as the beneficiary.

I consent to the collection, use and exchange of my personal information by my plan sponsor, the administration of my group benefits program, the agents retained by my plan sponsor of the administrator, the insurance company providing benefits, and/or other person who requires information for the purpose of group benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided to me and my plan sponsor from time to time. I confirm that I have obtained the consent required of my spouse and any dependent children over the age of majority to permit me to give the above consent as it relates to their personal information. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. I hereby apply for group insurance benefits under my plan sponsor's plan and authorize any required deductions. If I should receive a settlement from, or a judgement against, a liable third party for wage loss, extended health, or other benefits covered under my group plan, I agree and authorize the third party to reimburse the insurance company providing benefits up to the amount of benefits advanced to me pending such settlement or judgement. I consent to the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

I understand that on the date my insurance becomes effective I must be actively at work and on the date the insurance of my dependent(s) becomes effective they cannot be confined to hospital. I certify that the information given above is true and complete.

Employee Signature (digital signatures not accepted) **X**_____ Date _____

Employment Information: For a Plan Administrator / Employer to complete

$_____ Employee Earnings	☐ Monthly ☐ Annually ☐ Bi-weekly ☐ Weekly ☐ Hourly	Enrolled via EAS ☐	H.S.A Allocation (if applicable)	Hours Worked/Week	ID Number: (Internal Use)
Employee Occupation:		Division	Class	I confirm that this individual is an active permanent employee and the information I have provided is complete and true.	

Date of Hire* (New Employee)			**Date of Re-hire** (Re-hired Employee)		
MM	DD	YY	MM	DD	YY

X _____
Authorized Signature of Employer (digital signatures not accepted) **Date**

***The effective date will be determined by the date of hire and the waiting period as defined by your master application, unless otherwise advised.**
A copy of this form should be kept in the employee's file for your records